**Department of Health**

**ANDREW M. CUOMO**
Governor

**HOWARD A. ZUCKER, M.D., J.D.**
Commissioner

**SALLY DRESLIN, M.S., R.N.**
Executive Deputy Commissioner

MAR 29 2019

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMCS
7500 Security Boulevard, M/S S3-14-28
Baltimore, MD 21244-1850

Re: SPA #19-0017
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #19-0017 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective January 1, 2019 (Appendix I). This amendment is being submitted based upon enacted legislation. A summary of the proposed amendment is contained in Appendix II.

This amendment is submitted pursuant to §1902(a) of the Social Security Act (42 USC 1396a(a)) and Title 42 of the Code of Federal Regulations (CFR), Part 447, Subpart C.

Notice of the changes in the methods and standards for setting payment rates for general hospital inpatient services were given in the New York State Register on December 26, 2018.

A copy of pertinent sections of enacted legislation is enclosed for your information (Appendix III). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact Regina Deyette, Medicaid State Plan Coordinator, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 473-3658.

Sincerely,

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures
cc: Mr. Ricardo Holligan
Mr. Tom Brady

FORM APPROVED
OMB No. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER: 1 9 — 0 0 1 7

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: January 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Section: 42 CFR 440.130(d)

7. FEDERAL BUDGET IMPACT
a. FFY 01/01/19-09/30/19 $ 312.00
b. FFY 10/01/19-09/30/20 $ 416.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment: 4.19-A Part III Pages: 13, 14, 15
Attachment A Replacement Pages

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment: 4.19-A Part III Pages: 13, 14
Attachment A Replacement Pages

10. SUBJECT OF AMENDMENT
OASAS Medically Supervised Inpatient Withdrawal (FMAP=50%)

11. GOVERNOR'S REVIEW *(Check One)*

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME: Donna Frescatore

14. TITLE: Medicaid Director, Department of Health

15. DATE SUBMITTED: MAR 29 2019

16. RETURN TO
New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, NY 12210

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED

18. DATE APPROVED

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

**Appendix I**
**2019 Title XIX State Plan**
**First Quarter Amendment**
**Amended SPA Pages**

**SPA 19-0017**

**Attachment A**

**Replacement Pages: 13,14**

**Freestanding Medically Supervised Inpatient Withdrawal Services**

Medically supervised withdrawal services are for patients at a mild or moderate level of withdrawal, or are at risk for such, as well as patients with sub-acute physical or psychiatric complications related to alcohol and/or substance related dependence, are intoxicated, or have mild withdrawal with a situational crisis, or are unable to abstain yet have no past withdrawal complications. The fee methodology described here will apply only to freestanding (non-hospital) medically supervised inpatient withdrawal facilities that are certified by the Office of Alcoholism and Substance Abuse Services solely under Article 32 of the New York State Mental Hygiene Law. This methodology will not apply to Article 28 facilities.

Medicaid fees will be established using a cost-based fee methodology that is inclusive of both operating and capital reimbursement. There will be no capital add-on to these fees or any separate Medicaid reimbursement for capital costs. These fees will be effective on January 1, 2019 and will remain in effect until such time as they are revised with the approval of CMS.

The base year for new fee calculations under this methodology will be the most recent, substantially complete Consolidated Fiscal Report period available at the time of the calculation, and may vary by provider and service type based on the availability of such information. Prior to the fee calculation, base year cost information will be trended, using the Congressional Budget Office's Consumer Price Index for all Urban Consumers, to the start date of the fee period. Outlier cost data, meaning program cost data that deviates substantially from the expected value(s), will be removed from the fee calculation. Only allowable costs will be used in the fee calculation. To be considered as allowable, costs must be both reasonable and necessary, and in conformance with generally accepted accounting principles. The Commissioner of the N.Y.S. Office of Alcoholism and Substance Abuse Services will make the final determination on the allowability of any cost.

Per diem fees for each service will be determined using a cost-based methodology that recognizes both regional cost differentials and economies of scale. A regression model based on standardized statewide cost relative to service volume will be used to develop the fees. Individual provider reported facility-specific cost will be converted to statewide cost based on regional cost factors (see table below), the fees will then be developed based on a "statewide cost" basis. The calculated statewide fees will be converted to facility-specific fees based on program capacity or service volume and regional cost factors. The fees will be deemed to be inclusive of all service delivery costs and will be considered payment in full for fee-for-service Medicaid reimbursed services.

Due to the fact the many Medically Supervised Inpatient Withdrawal beds are certified as "swing beds", for existing facilities the "bed size" will not be based on certified program size and instead will be based on the reported all payer units of service from the base year, divided by 365, and rounded up to the next integer. For new MSIW facilities, the "bed size" will be based on 90% of the certified capacity rounded up to the next integer. Once initial cost report data is received for a new facility, the fee will be revised retroactively to the start date of the reporting period (opening date) based on the reported actual all payer units of service. Thereafter the fee will be based on the reported all payer units of service for the period two years prior to the fee period (or base year if a rebasing applies), unless the

[(6) With the approval of CMS, the service operating fees may be updated to adjust for programmatic changes or service operating cost variations not addressable by the annual trend factor. The process of updating service operating fees may include one or more of the following:

(i) the establishment of a new base year and fee cycle;
(ii) a change in the number of fee levels;
(iii) a change in the upper and/or lower service capacities of the fee levels; or
(iv) other necessary changes.

Capital add-on.

To be considered as allowable, capital costs must be both reasonable and necessary to patient care under Part 817. Allowable capital costs will be determined in accordance with the following:

(1) The Office will use, as its major determining factor in deciding on the allowability of costs, the most recent edition of the Medicare Provider Reimbursement Manual, commonly referred to as HIM-15, published by the U.S. Department of Health and Human Services' Centers for Medicare and Medicare Services.

(2) Where HIM-15 is silent concerning the allowability of costs, the commissioner will determine allowability of costs based on reasonableness and relationship to patient care and generally accepted accounting principles.

Allowable capital costs may include:

(1) the costs of owning or leasing real property;

(2) the costs of owning or leasing moveable equipment and personal property; and

(3) the cost of up to three months of pre-operational program start-up expenses, and associated interest, for new services, programs, or facilities for which initial reimbursement levels are being established. Pre-operational start-up costs may include, but are not limited to, rent, employee compensation, utilities, staff training and travel, and expensed equipment.

No capital or start-up expenditure for which approval by the office is required in accordance with the operating requirements of the office will be included in allowable capital cost for purposes of computation of provider reimbursement unless such approval will have been secured. For projects requiring approval by the office, reimbursement for capital costs will be limited to the amount approved by the commissioner.]

certified capacity changes in which case the fee will be based on 90% of the new certified capacity, effective on the date of the capacity change, and reconciled to actual service volume once that information becomes available. Facilities with fewer than 6 "beds" will use the 6 bed fee. Facilities with 120 or more "beds will use the 120 bed fee.

Statewide MSIW fees:

| Bed Size | MSIW Fees | Bed Size | MSIW Fees | Bed Size | MSIW Fees | Bed Size | MSIW Fees | Bed Size | MSIW Fees | Bed Size | MSIW Fees |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 6 | $492.73 | 26 | $413.83 | 46 | $386.67 | 66 | $370.41 | 86 | $358.92 | 106 | $350.10 |
| 7 | $483.77 | 27 | $411.98 | 47 | $385.68 | 67 | $369.75 | 87 | $358.43 | 107 | $349.71 |
| 8 | $476.14 | 28 | $410.20 | 48 | $384.71 | 68 | $369.09 | 88 | $357.94 | 108 | $349.32 |
| 9 | $469.52 | 29 | $408.49 | 49 | $383.77 | 69 | $368.45 | 89 | $357.46 | 109 | $348.94 |
| 10 | $463.67 | 30 | $406.84 | 50 | $382.85 | 70 | $367.82 | 90 | $356.99 | 110 | $348.56 |
| 11 | $458.44 | 31 | $405.26 | 51 | $381.95 | 71 | $367.20 | 91 | $356.52 | 111 | $348.19 |
| 12 | $453.72 | 32 | $403.73 | 52 | $381.07 | 72 | $366.59 | 92 | $356.05 | 112 | $347.82 |
| 13 | $449.41 | 33 | $402.26 | 53 | $380.20 | 73 | $365.99 | 93 | $355.60 | 113 | $347.45 |
| 14 | $445.47 | 34 | $400.83 | 54 | $379.36 | 74 | $365.40 | 94 | $355.14 | 114 | $347.08 |
| 15 | $441.83 | 35 | $399.45 | 55 | $378.53 | 75 | $364.82 | 95 | $354.70 | 115 | $346.72 |
| 16 | $438.45 | 36 | $398.11 | 56 | $377.72 | 76 | $364.24 | 96 | $354.25 | 116 | $346.37 |
| 17 | $435.29 | 37 | $396.82 | 57 | $376.93 | 77 | $363.68 | 97 | $353.82 | 117 | $346.01 |
| 18 | $432.34 | 38 | $395.56 | 58 | $376.15 | 78 | $363.12 | 98 | $353.39 | 118 | $345.66 |
| 19 | $429.57 | 39 | $394.34 | 59 | $375.38 | 79 | $362.57 | 99 | $352.96 | 119 | $345.32 |
| 20 | $426.96 | 40 | $393.15 | 60 | $374.63 | 80 | $362.02 | 100 | $352.54 | 120+ | $344.97 |
| 21 | $424.48 | 41 | $392.00 | 61 | $373.90 | 81 | $361.49 | 101 | $352.12 | | |
| 22 | $422.14 | 42 | $390.88 | 62 | $373.17 | 82 | $360.96 | 102 | $351.71 | | |
| 23 | $419.91 | 43 | $389.78 | 63 | $372.46 | 83 | $360.44 | 103 | $351.30 | | |
| 24 | $417.79 | 44 | $388.72 | 64 | $371.77 | 84 | $359.93 | 104 | $350.90 | | |
| 25 | $415.77 | 45 | $387.68 | 65 | $371.08 | 85 | $359.42 | 105 | $350.50 | | |

The regional cost factors applicable to this table are found on the following page.

[reimbursement, capital and start-up costs must be both reasonable and necessary, incurred by the provider, and chargeable to necessary patient care.

The capital add-on to the service operating fee will be calculated for each fee period on a provider-specific basis by dividing the provider's allowable capital costs for that fee period by the allowable patient days for that fee period. The capital add-on may be adjusted by the office on a retroactive or prospective basis to more accurately reflect the actual or anticipated approved capital cost.

New eligible RRSY providers.

(1) Once a new eligible RRSY provider has at least six months of cost and operating experience, they will submit reports at least 180 days prior to the beginning of the fee period for which a fee is being requested unless otherwise waived by the commissioner.
(2) Each new eligible RRSY provider which has less than six months of cost and operating experience will prepare and submit to the commissioner a budgeted cost report. Such report will:

(i) include a detailed projection of revenues and a line item expense budget with regard to staffing, non-personal service costs including capital;
(ii) include a detailed staffing plan;
(iii) include a projected month by month bed utilization program;
(iv) cover a 12 month period; and
(v) such budget report will be completed and submitted at least 180 days prior to the beginning of the rate year for which a rate is being requested.

(3) The service operating fee [and capital add-on ]for each new eligible RRSY provider will be calculated and reimbursed pursuant to these requirements.

(4) Upon submission of the financial reports the commissioner may adjust retroactively the eligible RRSY provider's existing capital add-on to more accurately reflect the reported operating costs and program utilization, based on patient days of the eligible RRSY provider.]

The geographic regions and regional cost factors applicable to the statewide fees derived from the table above and used to determine the final facility-specific free-standing medically supervised inpatient withdrawal fees are as follows:

| Region | Factor | Counties |
|---|---|---|
| 1 | 1.2267 | New York City |
| 2 | 1.2001 | Westchester |
| 3 | 1.1825 | Nassau, Suffolk, Rockland, Orange |
| 4 | 1.1009 | Dutchess, Putnam |
| 5 | 1.0317 | Erie, Niagara |
| 6 | 0.9710 | Madison, Onondaga, Oswego, Tompkins, Jefferson, Herkimer, Oneida |
| 7 | 0.9192 | Rest of State |

# Appendix II
# 2019 Title XIX State Plan
# First Quarter Amendment
# Summary

**SUMMARY**
**SPA #19-0017**

This State Plan Amendment proposes to revise the rate setting methodology for NYS Office of Alcoholism and Substance Abuse Services (OASAS) freestanding Medically Supervised Inpatient Withdrawal (MSIW) programs.

The program will move to site-specific per-diem fees, which are inclusive of capital costs, based on a regression model that uses normalized cost per bed in comparison to service volume. Fees will be assigned to each facility based on its base year service volume (as a proxy for bed size) and a regional cost factor. The fees for each bed size are detailed in the SPA.

**Appendix III**
**2019 Title XIX State Plan**
**First Quarter Amendment**
**Authorizing Provisions**

Included below is 43.01 and 43.02 - which we cite as authority to establish methods of payment:

§ 43.01 Fees and rates for department services.

(a) The department shall charge fees for its services to patients and residents, provided, however, that no person shall be denied services because of inability or failure to pay a fee.

(b) The commissioner may establish, at least annually, schedules of rates for inpatient services that reflect the costs of services, care, treatment, maintenance, overhead, and administration which assure maximum recovery of such costs.

In addition, the commissioner may establish, at least annually, schedules of fees for noninpatient services which need not reflect the costs of services, care, treatment, maintenance, overhead, and administration.

(c) The executive budget, as recommended, shall reflect, by individual facility, the costs of services, care, treatment, maintenance, overhead, and administration.

(d) All schedules of fees and rates which are established by the commissioner, shall be subject to the approval of the director of the division of the budget. Immediately upon their approval, copies of all schedules of fees and rates established pursuant to this section shall be forwarded to the chairman of the assembly ways and means committee and the chairman of the senate finance committee.

§ 43.02 Rates or methods of payment for services at facilities subject to licensure or certification by the office of mental health, the office for people with developmental disabilities or the office of alcoholism and substance abuse services.

(a) Notwithstanding any inconsistent provision of law, payment made by government agencies pursuant to title eleven of article five of the social services law for services provided by any facility licensed by the office of mental health pursuant to article thirty-one of this chapter or certified by the office of alcoholism and substance abuse services pursuant to this chapter to provide inpatient chemical dependence services, as defined in section 1.03 of this chapter, shall be at rates or fees certified by the commissioner of the respective office and approved by the director of the division of the budget, provided, however, the commissioner of mental health shall annually certify such rates or fees which may vary for distinct geographical areas of the state and, provided, further, that rates or fees for service for inpatient psychiatric services or inpatient chemical dependence services, at hospitals otherwise licensed pursuant to article twenty-eight of the public health law shall be established in accordance with section two thousand eight hundred seven of the public health law and, provided, further, that rates or fees for services provided by any facility or program licensed, operated or approved by the office for people with developmental disabilities, shall be certified by the commissioner of health; provided, however, that such methodologies shall be subject to approval by the office for people with developmental disabilities and shall take into account the policies and goals of such office.

(b) Operators of facilities licensed by the office of mental health pursuant to article thirty-one of this chapter, licensed by the office

for people with developmental disabilities pursuant to article sixteen of this chapter or certified by the office of alcoholism and substance abuse services pursuant to this chapter to provide inpatient chemical dependence services shall provide to the commissioner of the respective office such financial, statistical and program information as the commissioner may determine to be necessary. The commissioner of the appropriate office shall have the power to conduct on-site audits of books and records of such facilities.

(c) The commissioner of the office of mental health, the commissioner of the office for people with developmental disabilities and the commissioner of the office of alcoholism and substance abuse services shall adopt rules and regulations to effectuate the provisions of this section. Such rules and regulations shall include, but not be limited to, provisions relating to:

(i) the establishment of a uniform statewide system of reports and audits relating to the quality of care provided, facility utilization and costs of providing services; such a uniform statewide system may provide for appropriate variation in the application of the system to different classes or subclasses of facilities licensed by the office of mental health pursuant to article thirty-one of this chapter or licensed or operated by the office for people with developmental disabilities pursuant to article sixteen of this chapter, or certified by the office of alcoholism and substance abuse services pursuant to this chapter to provide inpatient chemical dependence services; and

(ii) methodologies used in the establishment of the schedules of rates or fees pursuant to this section provided, however, that the commissioner of health shall adopt rules and regulations including methodologies developed by him or her for services provided by any facility or program licensed, operated or approved by the office for people with developmental disabilities; provided, however, that such rules and regulations shall be subject to the approval of the office for people with developmental disabilities and shall take into account the policies and goals of such office.

# Appendix IV
# 2019 Title XIX State Plan
# First Quarter Amendment
# Public Notice

state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

*For further information and to review and comment, please contact*: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, or e-mail: spa_inquiries@health.ny.gov

## PUBLIC NOTICE

### Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health and the Office of Alcoholism and Substance Abuse Services hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional services to comply with Title 14 NYCRR, Chapter XXI, Parts 818, 817, 816. The following changes are proposed:

Institutional Services

Effective on or after January 1, 2019, The New York State Office of Alcoholism and Substance Abuse Services will change the Medicaid reimbursement for freestanding chemical dependence inpatient rehabilitation services (Title 14 NYCRR, Chapter XXI, Part 818), chemical dependence residential rehabilitation services for youth (Part 817), and freestanding chemical dependence medically supervised inpatient withdrawal services (Part 816) to a new fee-based methodology effective January 1, 2019. The new fee methodology will apply only to freestanding facilities that are certified solely under Article 32 of the New York State Mental Hygiene Law and shall not apply to facilities certified under Article 28 of the Public Health Law. The new Medicaid fees will be per diem fees established using a cost-based fee methodology that is inclusive of both operating and capital reimbursement. There shall be no capital add-on to these fees or any separate Medicaid reimbursement for capital costs.

The fees will be established using a regression model based on the relationship between normalized cost and program capacity. The calculated statewide fees, based on program capacity, will then be adjusted using regional cost factors (see below). Separate fee schedules will apply to each of the three program types.

Any changes in certified program capacity will result in a rate change effective on the same date, except that for medically supervised inpatient withdrawal, bed size will not be based on certified program capacity and instead shall be based on the reported all payer units of service. For new Medically Supervised Inpatient Withdrawal (MSIW) facilities, the "bed size" shall be based on 90% of the certified capacity rounded up to the next integer. Once actual service volume data is received for a new MSIW facility, the fee shall be revised retroactively to the opening date, based on the reported actual all payer units of service. Thereafter the MSIW fee shall be based on the reported all payer units of service for the period two years prior to the fee period (or base year if a rebasing applies), unless the certified capacity changes in which case the fee shall be based on 90% of the new certified capacity, effective on the date of the capacity change, and reconciled to actual service volume once that information becomes available.

The geographic regions and regional cost factors for the three services will be as follows:

| Region | Factor | Counties |
|---|---|---|
| 1 | 1.2267 | NYC |
| 2 | 1.2001 | Westchester |
| 3 | 1.1825 | Nassau, Suffolk, Rockland, Orange |
| 4 | 1.1009 | Dutchess, Putnam |
| 5 | 1.0317 | Erie, Niagara |
| 6 | 0.9710 | Madison, Onondaga, Oswego, Tompkins, Jefferson, Herkimer, Oneida |
| 7 | 0.9192 | Rest of State |

The estimated all shares impact (cost) of this proposal is $6.8 million per year. The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $1.7 Million (all shares).

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

*For further information and to review and comment, please contact*: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, or e-mail: spa_inquiries@health.ny.gov

## PUBLIC NOTICE

### Department of State

F-2018-1042

Date of Issuance – December 26, 2018

The New York State Department of State (DOS) is required by Federal regulations to provide timely public notice for the activities described below, which are subject to the consistency provisions of the Federal Coastal Zone Management Act (CZMA) of 1972, as amended.

**Appendix V**
**2019 Title XIX State Plan**
**First Quarter Amendment**
**Responses to Standard Funding Questions**

**APPENDIX V**
**HOSPITAL SERVICES**
**State Plan Amendment #19-0017**

**CMS Standard Funding Questions (NIRT Standard Funding Questions)**

**The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of the state plan.**

**1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)**

**Response:** Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular 2 CFR 200 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

**2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from**

**appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**
**(i) a complete list of the names of entities transferring or certifying funds;**
**(ii) the operational nature of the entity (state, county, city, other);**
**(iii) the total amounts transferred or certified by each entity;**
**(iv) clarify whether the certifying or transferring entity has general taxing authority; and,**
**(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).**

**Response:** Payments made to service providers under the provisions of this SPA are funded through a budget appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health.

The source of the appropriation is the Medicaid General Fund Local Assistance Account, which is part of the Global Cap. The Global Cap is funded by General Fund and HCRA resources.

There have been no new provider taxes and no existing taxes have been modified.

**3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

**Response:** The payments authorized for this provision are not supplemental or enhanced payments.

**4. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 447.272, States are prohibited**

**from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

**Response:** The rate methodology included in the State Plan for SUD outpatient and residential/inpatient services is a prospective methodology. We are unaware of any requirement under current federal law or regulation that limits individual provider's payments to their actual costs.

**5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

**Response:** The rate methodology included in the approved State Plan for institutional services is prospective payment. We are unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs. Additionally, at this time, there are no governmental providers of these services.

**ACA Assurances:**

**1. Maintenance of Effort (MOE). Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.**

**MOE Period.**

- **Begins on: March 10, 2010, and**
- **Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.**

**Response:** This SPA complies with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program.

**2. Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.**

**Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures**

**at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.**

**Response:** This SPA would [ ] / would not [✓] violate these provisions, if they remained in effect on or after January 1, 2014.

**3. Please indicate whether the State is currently in conformance with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.**

**Response:** The State does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

**Tribal Assurance:**

**Section 1902(a)(73) of the Social Security Act the Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular ongoing basis from designees of Indian health programs whether operated by the Indian Health Service HIS Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act ISDEAA or Urban Indian Organizations under the Indian Health Care Improvement Act.**

**IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.**

**a) Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**

**b) Please include information about the frequency inclusiveness and process for seeking such advice.**

**c) Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

**Response:** Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 17-0065, and documentation of such is included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.